Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ASC OF OPELOUSAS

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-13-3163-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The provider is not in agreement with the initial payment received on this claim. The payment received does not justify the cost of the supplies and materials used for this surgery. Also, the provider did not received payment for the implants used for surgery. The provider was expecting 85% of the billed charges. This amount is base4d on the 90/10 fee schedule for Louisiana Workers Compensation plus an additional 5% discount."

Amount in Dispute: $26,249.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Charges were submitted by a LA provider but this is a TX jurisdiction claim. Charges were submitted a UB92 form but provider indicates they are an ambulatory surgery center which, under TX Medicare based guidelines are requires to bill on a CMS 1500 form."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2013	Ambulatory Surgical Care Services CPT Code 29827	$25,599.02	$2,864.17
	Ambulatory Surgical Care Services CPT Code L9900	$650.00	$0.00
TOTAL		$26,249.02	$2,864.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.10, effective August 1, 2011, requires ASCs to bill on CMS-1500s.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for

ambulatory surgical care services The services in dispute were reduced/denied by the respondent with the following reason codes:

- Z710-The charge for this procedure exceeds the fee schedule allowance.
- Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
- W3-Additional payment made on appeal/reconsideration.
- Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- X936-CPT or HCPC is required to determine if services are payable.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Does medical fee dispute resolution have jurisdiction to review this dispute?
2. Did the requestor submit the bill for the disputed services on the correct bill?
3. Is the requestor entitled to additional reimbursement for CPT code 29827?
4. Is the requestor entitled to reimbursement for code L9900?

Findings

1. The requestor provided ASC services in the state of Louisiana on April 11, 2013 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. According to the explanation of benefits, the respondent raised the issue of "X936-CPT or HCPC is required to determine if services are payable." The respondent states in the position summary that "Charges were submitted a UB92 form but provider indicates they are an ambulatory surgery center which, under TX Medicare based guidelines are requires to bill on a CMS 1500 form."

   28 Texas Administrative Code §133.10(f)(1) requires ASCs to bill on CMS-1500s and outlines the information to complete the bill.

   A review of the submitted medical bill finds that the requestor billed on a UB92. The Division finds that the requestor did not bill for the disputed services in accordance with 28 Texas Administrative Code §133.10(f)(1).

3. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 29827 is defined as "Arthroscopy, shoulder, surgical; with rotator cuff repair."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   According to Addendum AA, CPT code 29827 is a non-device intensive procedure.

   The City Wage Index for Louisiana is 0.7718.

   The Medicare fully implemented ASC reimbursement for code 29827 CY 2013 is $2,177.30.

   To determine the geographically adjusted Medicare ASC reimbursement for code 29827:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,088.65

This number multiplied by the City Wage Index is = $840.22.

Add these two together = $1,928.87.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

The MAR is $4,532.84. The respondent paid $1,668.67. The difference between the MAR and amount paid is $2,864.17; this amount is recommended for additional reimbursement.

4. Per the submitted *Table of Disputed Services*, the requestor is seeking reimbursement for code L9900. Code L9900 is defined as "Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code."

   28 Texas Administrative Code §134.402(d) states, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."

   Per CMS reimbursement guidelines, code L9900 is a status "N1-packaged service/no separate reimbursement is allowed" code; therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,864.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,864.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/29/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.